H-KISS FAX REFERRAL FORM

Please complete all areas. If information is not available for some areas, you may skip these sections and H-KISS will follow up.

Call Date to H-KISS: ___/___/___ **Referral Source Name:** _____ **Ph #:** _____

Relationship to Child: ☐ Parent ☐ Pediatrician ☐ Other: _____

Address (if not parent): _____

How Referral Source Became Aware of H-KISS: _____

Child Name: _____ **Date of Birth:** _____

Gender: ☐ M ☐ F **Age:** _____ years _____ months ☐ Gestational Age < 32 weeks

☐ Birth weight < 1500 grams ☐ Estimated date of discharge _____

Area(s) of Concern: ☐ Cognitive ☐ Physical ☐ Communication ☐ Social/Emotional ☐ Adaptive

Developmental Concerns: _____

_____

_____

_____

_____

Medical Concerns/Recommendation_____

_____

_____

_____

Screenings Done: ☐ ASQ ☐ DIAL-R ☐ Denver ☐ CBCL ☐ ASQ-SE ☐ HELP

☐ Audiological (Include Newborn Hearing Screening) ☐ PEDS ☐ Other: _____

Significant Results: _____

Pediatrician: _____ Ph #: _____

MD Specialist(s): _____

Agencies Involved w/Child: ☐ CWS ☐ CSHNB ☐ ECSP ☐ EIS ☐ PHN ☐ Guardian Ad-Litem

☐ Healthy Start ☐ HomeReach ☐ Kaiser ☐ Kapi'olani ☐ Tripler ☐ Other: _____

☐ EPSDT (Name of Agency): _____

Primary Caregiver Name(s): _____

Relationship to Child: ☐ mother ☐ father ☐ foster parent ☐ guardian ☐ other: _____

Residence Address: _____

Mailing/Other Address: _____

Ph # (h): _____ (w): _____ (other): _____ **Best call time**: _____

Directions to Home: _____

_____

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(O'ahu) 973-9633 ◆ (Neighbor Islands) 1-800-235-5477 ◆ **Fax: (808) 973-9655**

Form Revised 9/2/05